Mother's Name or Imprint: Baby's Name or Imprint:

New Jersey Department of Health and Senior Services
MODULE 6 - PARENT/GUARDIAN MODULE

(To be completed by registered nurse, birth attendant, or licensed audiologist, and maintained in the infant's chart as part of the Medical Record.)

INFORMATION ON PARENT/GUARDIAN/AGENCY

1. Relationship of Guardian to Child:

   1 ☐ Mother 2 ☐ Father 3 ☐ Other Guardian

2. Guardian (includes agencies) at Time of Discharge:

   _____ _____ _____
   (Last Name) *(First Name)* *(MI)*

3. Guardian Mailing (Street) Address:

   _____
   (Street Address)

   _____ _____ _____
   (City) *(State)* *(Zip Code)*

4. Guardian Telephone Number: ( ) _____

FUTURE PEDIATRIC CARE/IMMUNIZATIONS

1. Check Type of Provider of Future Pediatric Care/Future Immunizations:

   01 ☐ Private Physician
   02 ☐ HMO or Health Plan
   03 ☐ HealthStart
   04 ☐ Community Health Center
   05 ☐ GardenState
   06 ☐ Hospital's Clinic
   07 ☐ Other Clinic
   08 ☐ Other, Specify: _____
   09 ☐ None
   10 ☐ Unknown

2. Name of Pediatrician, Family Doctor, Clinic or Health Department, if known:

   _____

NEWBORN HEARING SCREENING RISK

1. Is there a family history of hereditary childhood sensorineural hearing loss?
   Family history of hereditary (in a blood relative) childhood (congenital or delayed onset) sensorineural hearing loss. This does NOT INCLUDE hearing loss due to accident, illness, ear infections or old age.

   1 ☐ Yes 2 ☐ No

PARENTAL INFORMED CONSENT

I have received materials on the Newborn Hearing Screening Program. I understand that my baby will be screened for possible hearing loss before discharge or by one month of age.

☐ For religious reasons, I will NOT permit my baby to participate in the Newborn Hearing Program.

_____ ___ ___ / ___ ___ / ___ ___ ___
Signature of Parent/Guardian *Date Signed (Month/Day/Year)*